

SECTION J – COORDINATION OF CARVED OUT SERVICES

J.1 Describe how you will coordinate with the Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO) for the management of shared members, including processes for reciprocal referral for needed services and prescription management (including but not limited to Sections 6.4, 6.34, 6.37 of the RFP). Include how you will engage and educate primary care providers in their role in the provision of basic behavioral services and the coordination of co-existing conditions. Include a description of the role Medical Director for Behavioral Health will play in these efforts.

Experience and Approach

Louisiana Healthcare Connections (LHCC) and the Statewide Management Organization (SMO) have developed proven procedures over the past two years to coordinate the care of Bayou Health members who require specialty behavioral health (BH) services. These procedures are detailed in our Memorandum of Understanding (MOU) with the SMO which formalizes our coordination and mixed services protocols, and reciprocal referral processes. Through the MOU, we facilitate the integration of physical and behavioral health and provide for the appropriate continuity of care across programs.

LHCC's Case Managers and pharmacist, and the SMO's case managers, participate in twice-monthly telephonic and quarterly face-to-face rounds to discuss shared member cases. These rounds include discussion of information such as progress and monitoring results of complex members, case management approaches, and care coordination needs and effectiveness. LHCC and SMO staff attend annual meetings with DHH and OBH to discuss targeted efforts; updates to policies, procedures, and regulations; and annual review of services. Our Chief Medical Director, Vice President, Medical Management, and other staff, as needed, such as Pharmacy staff, participate in these meetings. Under the new contract, our BH Medical Director (BHMD) (described in more detail below) will also participate and serve as our lead liaison in these meetings, as well as in the rounds described above for co-managed members.

Since the execution of our MOU, LHCC and the SMO have co-managed 157 members who have co-morbid medical and BH conditions.

LHCC brings to this partnership a wealth of national behavioral health (BH) experience through Cenpatico Behavioral Health, LLC (Cenpatico), our behavioral health affiliate and subcontractor. Cenpatico achieved full NCQA accreditation as a managed BH organization in 2010, and has experience serving many Medicaid populations (including TANF, CHIP, ABD, and Foster Care) and Medicare, and currently manages BH services for approximately 1.7M members across 14 states. In four other states in which BH services are carved out of the MCO capitation and contracts, Cenpatico supports our affiliate health plans by providing expertise and evidence-based best practices to assist plan staff in integrating Medicaid-covered medical and pharmacy services with BH services. Cenpatico's experience is broader than traditional managed care contracts with states, and includes working agreements with stakeholder agencies and organizations such as local governments; adult corrections and juvenile corrections; Departments of Children and Families; Departments of Housing; Departments of Developmental Disabilities; Departments of Long Term Care; Departments of Vocational Rehabilitation; school districts, FQHCs and Rural Health Clinics; and local advocacy groups and community partners.

Drawing on Cenpatico's expertise as well as our experience with Bayou Health members since program implementation, including those we have co-managed with the SMO, LHCC understands and has developed processes to reflect the critical importance of integrating physical and behavioral health services and using a whole-person approach. We have been a leader in working aggressively and continually to improve coordination of Bayou Health services and carved-out behavioral health services. While coordination of these carved-out services does pose challenges, LHCC has made every effort to

bridge the separate systems providing services to members in order to improve their quality of life and outcomes. Processes and protocols we have developed to improve our ability to coordinate effectively with the SMO and ensure an integrated approach to members with BH conditions include but are not limited to the following.

- ***Dedicated BH Case Management Staff.*** LHCC employs dedicated Behavioral Health (BH) Case Managers to assist with identifying and coordinating services for members with BH needs, including, but not limited to co-occurring conditions. Our BH Coordinator (a social worker Case Manager) has developed processes to coordinate BH care between the PCP and BH provider, promoting best practices for the care of BH disorders in a primary setting; and served as LHCC's liaison with state entities and the provider community. The BH Coordinator, in conjunction with Cenpatico, will provide Case Managers with in-depth training on identification and screening of BH conditions and referral procedures, as well as assisting members without a diagnosed BH disorder (who would benefit from psychosocial guidance) adapt to a newly diagnosed chronic medical disorder. Under the new contract, the BH Coordinator will work in collaboration with our new BH Medical Director, who will bring an even deeper level of clinical knowledge to these tasks.
- ***Point of Service Coordination.*** Following the successful practice of Cenpatico and other affiliate plans, we have located Program Specialists (social workers on our Case Management staff) within the community, such as onsite at a Community Health Clinic and an FQHC. We have strategically located other Program Specialists throughout the area in order to span the state. Two of our Program Specialists are located in large clinics, Affinity Health Group in Monroe, and David Raines Community Health Center in Shreveport; and we have two other Program Specialists located in Lake Charles and New Orleans. These embedded staff enable us to identify members who need or are seeking BH care, and provide immediate coordination assistance as well as assess other needs.
- In-person member contact can improve our ability to engage members in their care, and locally based staff provide access to in-depth knowledge of area resources and community cultures. These staff can also assist our Transition of Care Team by providing in-person post-hospitalization outreach for members within their region. They can provide valuable assistance to help ensure, for example, that follow-up appointments with PCPs are scheduled and kept. They also can help identify barriers and assist in providing solutions, and refer members to appropriate services and resources, as needed.
- ***Clinical BH Expertise within Our Quality Structure.*** Because we understand the importance of integrating BH expertise within all aspects of our operations to ensure an organization-wide focus on holistic care, our Quality Assessment and Performance Improvement Committee (QAPI Committee) invited a BH provider to join the Committee. This BH provider participates as an expert in directing our initiatives for coordinating medical and BH services. For example, the QAPI Committee developed a performance improvement project (PIP) to track the members we co-manage with the SMO, and evaluate outcomes such as reduction in medical costs, improved clinical outcomes, and member/provider satisfaction. Under the new contract, our BH Medical Director will also participate on the QAPI Committee to bring additional BH expertise to our focus on medical/behavioral integration.
- ***Leveraging Pharmacy Data to Support an Integrated Approach.*** Since initial Bayou Health pharmacy benefit implementation, LHCC has been responsible for BH pharmacy management. Having access to BH pharmacy data has enabled us to identify members with BH needs, and identify those who may require referral to, and co-management with, the SMO. This data has also helped us with drilling down on and addressing utilization trends for these members, such as repeat ED visits or readmissions related to their BH condition. For example, we review anti-psychotic medications to identify polypharmacy concerns.

LHCC understands and will comply with all DHH requirements relating to Coordinating with the Louisiana Behavioral Health Partnership State Management Organization (SMO) including, but not limited to, Sections 6.4. Behavioral Health Services; 6.29, Care Coordination, Continuity of Care, and Care Transition; 6.30. Continuity of Care for Pregnant Women; 6.32. Continuity of Care for Individuals with Special Health Care Needs; 6.33. Continuity of Care for Pharmacy Services; 6.34 Continuity for Behavioral Health Care; 6.37. Case Management; 4.2.4 Behavioral Health Medical Director; and all other relevant contractual and regulatory requirements.

Coordination with the SMO for Management of Shared Members

Our Case Managers work with SMO staff to coordinate the member's Bayou Health services with needed specialty BH services. Our approach to coordination, integration, and continuity of care for shared members includes the following components:

- Identifying members for referral to the SMO
- Comprehensive assessment
- Reciprocal referral process to ensure members are connected to the appropriate entity for needed care
- Integrated care plan development and monitoring, including a reciprocal prescription management process, coordinated transitional care planning, and follow-up
- Member and provider education to ensure awareness of the availability of SMO services and how to access them
- Initiatives to improve integration of care.

Identifying Members for Referral to the SMO. Case and Utilization Management staff identify members who would benefit from collaborative co-management through monthly or more frequent analyses of data sources, such as those shown in the table below.

Selected Sources Used to Identify Members for Possible SMO Referral	
Pharmacy data	Readmission reports
Claims or encounter data	Predictive modeling software
UM data (e.g. hospital admissions, inpatient census, prior authorization data, concurrent review data)	State/CMS Enrollment Process and other State/CMS supplied data
ED Utilization reports	Hospital Staff and/or Hospital discharge data
Enhanced detection by healthcare providers, including physicians, other practitioners, and ancillary providers	Information provided by members or their care givers, such as data gathered from Health Risk Assessments

We also identify members through calls to our Member Call Center or NurseWise, our 24/7 nurse advice line; and referrals from community and social service agencies. In addition, staff review these data sources to identify members who may have co-occurring medical and BH conditions. For example, we may identify claims for specialty BH services in the two years of historical claims data provided by DHH for new members. Review of pharmacy data may indicate claims for a medication taken by individuals with a BH condition, such as antipsychotics.

Comprehensive Assessment. When we identify such members, a Case Manager contacts the member to complete a comprehensive assessment of the member's risk factors, clinical co-morbidities, and special

health care needs. A primary goal of the assessment is to determine whether the member has specialty BH needs and/or would benefit from co-management with the SMO.

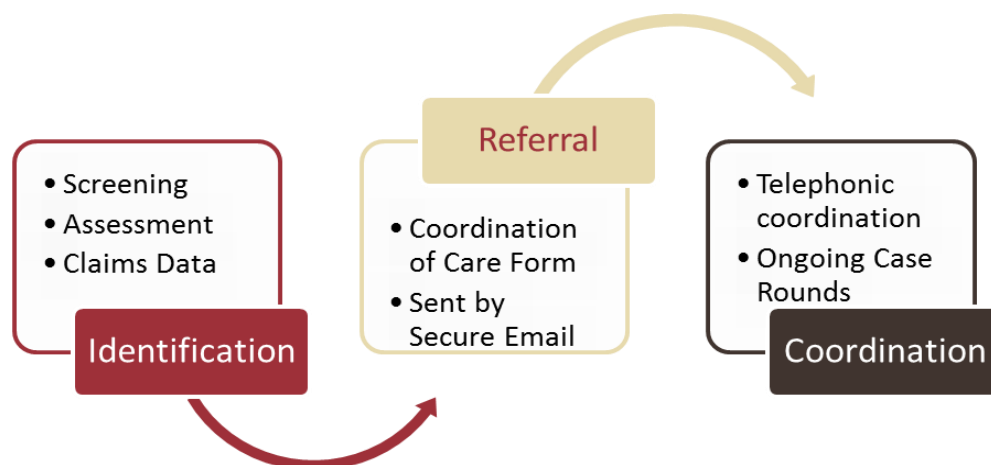
Our Case Manager completes the assessment in conjunction with the member, caregiver/family and informal supports as desired; existing network and non-network providers; and any previous case manager, including the member's SMO BH care manager if known, to identify and address the member's medical, BH, social and other needs, preferences, and goals. Information we gather during the assessment includes, but is not limited to:

- Member clinical history and status
- Member motivation and consent to treatment
- Medications with focus on poly-pharmacy management
- Current and past BH therapies
- Functional status related to activities of daily living
- Mental health status including psycho-social factors and cognitive function
- Caregiver resources, including family involvement and their participation in decision making
- Life planning activities, including wills; living wills, or advance directives; and cultural and linguistic needs and preferences.

Our assessment also includes information about diagnoses and co-morbidity risks, comprehension of medication regimen, hospital and ED use, activities of daily living, pain levels, confidence level in ability to manage primary condition, presence of behavioral health conditions and disorders, psychosocial barriers to treatment compliance, and cultural and religious beliefs that affect health status. The assessment helps to further identify clinical history and needs that may not be available through claims data and predictive modeling. For example, we may identify social or economic constraints, such as lack of financial and/or family support; or access to care issues, including transportation.

If the assessment indicates the need for specialty BH services, or that the member would benefit from co-management, we take action to refer the member to the SMO, as described below.

Process for Reciprocal Referrals. In collaboration with the SMO, LHCC has implemented secure email accounts and Coordination of Care referral forms to exchange referrals. Case Management staff send and receive referrals to/from SMO care management staff, and document each referral in the member's TruCare Care Plan. Case Managers also follow up with the member and the SMO on all referrals to ensure the member accesses needed care.



Referrals to the SMO. When we identify a member for referral, the Case Manager completes a Coordination of Care form with pertinent information about the member's assessment results. The Case Manager sends the form to SMO case management staff via secure email in a timeframe consistent with the urgency of the member's needs, but not to exceed three calendar days for routine referrals, and within one business day for urgent referrals. Our Case Managers continue to provide assistance with accessing the services for which we provided a referral, such as assisting with transportation scheduling.

In addition, LHCC and the SMO track names of shared members who visit the ED, and generate reports including the name of members and dates of services. The SMO currently distributes the reports to LHCC monthly. Under the new contract, LHCC's Quality Improvement (QI) Department will begin generating a report of our members who visit the ED and distribute the report to the SMO monthly.

For members calling to request non-emergent specialized BH services, a Customer Service Representative (CSR) who receives the call provides education about these services and how to access them. The CSR offers to refer the member to our Case Management Department for a comprehensive assessment. Once the Case Manager completes the assessment, s/he refers the member to the SMO as indicated by the assessment.

If a member or member's family expresses an emergent need for specialized BH services to any LHCC staff via phone or in person, our staff assist the member with seeking help from the nearest emergency medical provider. The Case Manager outreaches to and follows up with the member within 48 hours to establish that appropriate services were accessed, and to provide assistance in scheduling appointments for follow up care and transportation.

Referrals from the SMO. We document receipt of all SMO referrals in TruCare, which alerts the Case Manager to follow up with the SMO care manager. Our Case Manager contacts the SMO care manager within three business days of receipt of a referral for routine referrals, and within one business day if the referral is marked urgent.

Integrated Care Plan Development and Monitoring. LHCC Case Management staff and SMO care managers collaboratively develop an integrated care plan for members with co-occurring medical and BH conditions that require co-management to ensure integration and improve outcomes. LHCC and SMO staff work together with the member, family, and providers on Care Plan development, and this may include joint conferences to discuss the member's assessment results with a provider. The Care Plan is individualized and identifies the member's long and short term goals; desired service types, amounts and settings; member and caregiver/family participation, including the member's plan for addressing barriers; and community linkages and support. The Care Plan reflects Bayou Health covered services as well as SMO covered services, along with any other services the member may receive, such as 1915 (c) waiver services or community resources.

Our Case Managers document the integrated Care Plan in TruCare, our member-centric health services management platform that integrates Case/Care, Chronic Care, and Utilization Management services. TruCare allows us to proactively monitor members, efficiently document the impact of our efforts, pinpoint where care is needed, and implement customized intervention strategies. Case Managers use TruCare to plan and track coordination activities with providers, and create reminders to follow up with a member to make sure they accessed scheduled behavioral health services.

TruCare enables all staff on the member's Integrated Care Team (IC Team) to see a holistic view of the member's needs and all authorized services. Based on the member's updated Care Plan, the Case Manager schedules referrals and provides authorizations to the appropriate providers. Once the integrated Care Plan is developed, the Case Manager ensures that the member understands and agrees to it, and agrees to permit the Care Plan coordination with the SMO and behavioral health provider. We document this agreement in the member's file in TruCare. The Case Manager also commences follow-up contact with the member to ensure all services are initiated according to the Care Plan and meet the member's

needs. They also forward the new care plan to the member's PCP and share the Care Plan with the SMO care managers.

LHCC Case Managers and SMO care managers collaboratively share care plan updates to inform the member's integrated Care Plan and regularly discuss updates. Our Case Manager reviews the member's BH clinical information provided by SMO staff and/or identified via another source (such as claims for hospital and ED services showing a BH diagnosis) to assure the member is receiving appropriate BH care. If the member does not appear to be receiving needed specialty BH care, the Case Manager:

- Contacts the medical provider to ask about a BH consult
- Assists the member, or coordinates with the BH care manager, to make arrangements for the BH consult
- Follows up with SMO staff and the member, as needed, to make sure a BH consult occurs.

Joint Rounds. LHCC's Case Management staff, pharmacist, and the SMO case management team conduct joint rounds for shared members bi-monthly via phone or face to face. Going forward, our BH Medical Director will also participate. Others who may participate include, but are not limited to the SMO Medical Director and LHCC's OB Medical Director, Chief Medical Director, MemberConnections™ Representatives, Utilization Management staff, and Transition of Care staff handling post-discharge follow-up and monitoring. During joint rounds, we discuss shared members' care progress, potential medication interactions, and member compliance. We also discuss over- and under-utilization and prescribing practices, such as for ADHD. We determine any access or barriers to care and develop strategies to assist the member to overcome the barrier. Joint rounds participants also discuss pending discharges for members who are in the hospital or psychiatric facility. We coordinate transition planning for members with an inpatient stay, as described below.

Reciprocal Prescription Management. LHCC's pharmacist participates in joint case rounds to provide expert analysis of, and input on, member adherence, drug interactions, over prescribing, and over-and under-utilization for both medical and BH medications. Since LHCC will no longer be responsible for pharmacy management of BH medications prescribed by a BH specialty provider, we are working with the SMO to obtain access to these claims data. We also will coordinate to address drug interactions identified by the SMO during prospective review of drug utilization, such as during joint rounds, and through LHCC Case Manager collaboration with SMO staff on Care Plan monitoring and sharing information with prescribers. We will continue to discuss all medications regardless of payer during joint rounds.

To improve appropriate prescribing for psychotropic drugs, LHCC will introduce a new Psychotropic Medication Utilization Review (PMUR) Program. Our program is based on the successful PMUR program developed by Cenpatco and our Texas affiliates to improve psychotropic medication utilization among children in foster care. The program is a proven means of assuring appropriate utilization of psychotropic drugs by PCPs and other non-BH specialty providers, reducing the incidence of adverse drug effects, and reducing unnecessary drug costs. Because we understand there will be a claims lag with the SMO managing the BH pharmacy claims, our BH Medical Director and PMUR Team will reach out as needed to SMO providers when LHCC has SMO claims data showing psychotropic drug use to verify the drug therapy the member is currently using. The BH Medical Director or PMUR Team will also inform the SMO provider of the medications prescribed by LHCC network providers (in case the SMO provider does not have access to LHCC claims sent to the SMO). Our BH Case Managers will assist in collaboration and coordination of information.

Coordinated Transition Planning. For co-managed members with a medical inpatient stay, or who are discharged from the ED, our concurrent review nurses and Transition of Care (TOC) Team coordinate with the assigned LHCC Case Manager to share information as needed with SMO staff, and arrange for

any BH provider consultation and follow-up that may be necessary. The LHCC Case Manager works closely with concurrent review and TOC staff to stay apprised of the member's progress, needs, and anticipated discharge date, and shares this information with the SMO care manager. Throughout the inpatient stay and through the transition period, we share all information about the admission and the transition plan with the SMO care management team via a bi-weekly report, and, as needed, via telephone and/or electronic communication. LHCC and SMO staff also discuss the member's case during joint rounds to make recommendations for the transition plan and follow-up.

LHCC staff verify with the SMO care manager whether the member has an existing relationship with an outpatient BH provider. If so, we request contact information and attempt to involve that provider in transition planning to ensure continuity of care. TOC staff coordinate with the member, the LHCC and SMO staff co-managing the member, and providers to ensure necessary follow-up appointments are scheduled prior to discharge. For example, when we are notified by the SMO regarding a member with an inpatient BH stay, our Case Manager coordinates with the SMO care manager to schedule the 14 day follow-up appointment prior to discharge. If we are notified of the inpatient BH stay, our concurrent review or Case Management staff work with the SMO to ensure all authorizations for post-discharge Bayou Health services are in place prior to discharge, including authorizations for medications covered by LHCC. We continue the medication prescribed to a member in a state mental health treatment facility for at least 60 days after the discharge, unless our Behavioral Health Medical Director and the facility's prescribing physician determine that the medications are not medically necessary or potentially harmful to the member.

TOC staff attempt to contact the co-managed member within 72 hours of discharge from an inpatient medical stay to determine their progress and whether they are appropriately accessing post-discharge care, and educate the member about the symptom response plan. TOC staff ask members about any changes in their medications and if they are having trouble filling their prescriptions. They provide education about medication management, assist the member in connecting with a provider and/or pharmacy to obtain refills as needed, and/or work with the LHCC Case Manager and pharmacist and SMO care manager to identify pharmaceutical needs and issues. We coordinate medication compliance monitoring with SMO staff so that the entire care team has full information about the member's medications, side effects, and barriers to adherence.

TOC staff coordinate with SMO staff to follow up with BH providers to ensure recommended services are in place and have been accessed by the member. TOC staff also assist with referrals, and scheduling any additional post-transition visits or services that are not yet scheduled, such as visits with other specialists recommended during a post-discharge follow-up appointment.

Member Education. LHCC educates all members about carved out behavioral health services, how to access them, and the assistance available through LHCC. We accomplish this through the Member Handbook, Member Portal, newsletters, our toll-free Member call center, and clinical and outreach staff, as well as written materials. Our Member Handbook, which is included in the New Member Welcome Packet mailed to all new members and available on our Member Portal, includes information about accessing BH services and obtaining LHCC assistance. Our secure Member Portal provides education about signs and symptoms that may indicate a BH issue, and how to contact LHCC if the member experiences such signs or symptoms. Our CSRs, Case and Chronic Case Management staff, and NurseWise staff educate members about BH services when they call our Member Call Center or NurseWise asking about the services. In addition, our Case Managers educate members regarding appropriate utilization of ED services, including referral through the SMO to community BH specialists for BH emergencies, as appropriate.

Engaging and Educating PCPs

Well-supported providers are the foundation of our approach to integrating medical and BH care. We educate, train, and monitor network providers on our coordination requirements and processes. We also distribute release of information forms per 42 CFR Section 431.306 and provide training on its use. Our Provider Manual details the use of the release of information forms.

Through their regular long-term contact with members, PCPs are often in the best position to identify potential or actual BH conditions that may require specialty BH care. LHCC educates PCPs on topics such as how to screen for, and identify, BH disorders; how to refer members for specialty BH services; and best PCP practices in coordination and treatment. They must document in the medical record any BH screenings, DSM-IV diagnoses, and other BH-related assessment or outcome information. Because nurse practitioners also play an important role in treating children with behavioral disorders, including ADHD, in the primary care setting, we will include them in all provider education opportunities.

Our Provider Relations staff offer in-person training in provider offices and community locations. This in-person training allows our staff to obtain immediate feedback on areas of uncertainty, and to answer specific questions providers have about meeting language and communication needs, and securing interpreter services for members. We provide additional information about coordination and quality initiatives through Provider Newsletters, the Provider Manual, and group trainings and webinars. We support providers by providing clinical practice guidelines for detection and treatment of common BH disorders. Providers will be able to download from the Provider Portal a form to obtain any required member consent for the provider and specialty BH provider to share information about the member.

We provide ongoing provider trainings on evidence-based practices, effective treatment planning, and other topics related to co-occurring diagnoses both in person and through regularly scheduled webinars. With the addition of our BH Medical Director, we plan to enlist services to develop targeted education and training for providers related to commonly encountered BH issues frequently treated by PCPs.

We understand the importance of engaging and educating PCPs in their role in the provision of basic behavioral health services and coordination of co-existing conditions and to support integration of behavioral health and physical health services. LHCC supports our PCPs to improve their capabilities in identifying behavioral health issues and providing basic services or referring members appropriately to the SMO specialty behavioral health providers, and we will continue to seek opportunities for integrating behavioral health services under the new contract. Some of the initiatives we intend to pursue include an enhanced behavioral health training program, an incentive for our Premier Providers (a reimbursement category for the providers who have agreed to the highest level of engagement with and coordination for our members) that includes focused patient coordination, and a pilot grant program to enable providers to supplement staff with licensed clinical social workers.

Enhanced Behavioral Health Training. In conjunction with Cenpatico, and with oversight by our BH Medical Director, LHCC will provide specialized training and technical assistance to PCPs, FQHCs/RHCs and PCMH providers, and school personnel. Dedicated Clinical Trainers will conduct training in group settings, webinars, and in person. Our Clinical Trainer will educate providers on topics such as how to screen for, identify, and treat behavioral health disorders; how to identify and treat co-existing mental health and substance abuse disorders; when and how to refer members for behavioral health treatment; and best PCP practices in coordination of behavioral health treatment. LHCC will work with providers to identify specific topics by sending an annual survey to assess their training interests and needs for the upcoming year. In addition, Providers can submit training requests at any time via our Provider website. Training topics can be customized and cross-trained for any provider type. Training topics will include, but are not limited to those in the table on the following page:

Behavioral Health Training Topics	
<ul style="list-style-type: none"> • Integrated Health Care • Behavioral Health 101 • Diagnosis Specific <ul style="list-style-type: none"> ○ ADHD ○ Depression ○ Anxiety Disorders • Psychotropic Medications • Referral and Screening • Recovery Model • Cultural Competence • Poverty Competence • Trauma Informed Care • Member Engagement Strategies <ul style="list-style-type: none"> ○ Motivational Interviewing ○ Positive Psychology ○ Strengths Based Model 	<ul style="list-style-type: none"> • Behavior Management Strategies • DSM-5: An Overview of Changes • Co-occurring Disorders • Grief and Loss • Titrating Outpatient Services • Medical Necessity Criteria • SMART Goals • PCP Tool Kits • Behavioral Health Screening Tools <ul style="list-style-type: none"> ○ PHQ2 and PHQ9 (Depression) ○ CAGE-AID (Substance Abuse) ○ GAD-7 (Anxiety) ○ Vanderbilt (ADHD) • Suicide Risk and Assessment • Prevention and Early Identification • Caregiver Strategies

We will also provide our PCP Toolkits on the Provider Portal. These toolkits offer screening, disease, and diagnosis-specific information; prescribing guidelines; and evidence-based treatment information on conditions that may effectively be treated in the primary care setting. This includes, but is not limited to depression, ADHD, anxiety, and substance abuse.

For PCPs who already have behavioral health professionals on staff, our enhanced training offers Continuing Education Units (CEUs) for select behavioral health professions including Licensed Professional Counselors and Licensed Addiction Counselors.

Enhanced Rates/Incentives for Integrated Care. LHCC will offer our Premier PCP providers (a payment model category that includes the providers most willing to engage with our members and coordinate with our Case Management Program) a financial incentive for Focused Patient Coordination, which includes coordination of Bayou Health and other services, including referral to the SMO for specialty behavioral health needs.

Primary Care/Behavioral Health Integration Pilot Programs. LHCC will pilot a program with North Oaks Pediatrics, Children’s Clinic of Southwest Louisiana, and Pediatric Center of South Louisiana to improve behavioral health integration. LHCC will provide an unrestricted grant for these providers to hire an LCSW for behavioral health intervention and counseling. This initiative will support more accurate diagnosis and treatment for behavioral health disorders such as ADHD. Based on the success of this pilot program, and an enhanced education program for pediatricians to improve treatment of behavioral health conditions in the primary care setting, LHCC will explore a competitive grant program for these and other providers.

Collaboration with Other Bayou Health MCOs. In addition to the targeted training, incentives, and pilot programs for our network providers, we also participate in joint Bayou Health MCO outreach to engage all Bayou Health providers related to integrating care. For example, LHCC participates in quarterly summit meetings attended by PCPs, other plans, and providers from around the state to share information. These summits were initially implemented in 2013 to focus on resources in each region, and facilitate communication among Bayou Health Plans to understand the needs of each community and the issues PCPs deal with on a daily basis. By participating in this quarterly meeting, we have deepened

relationships among clinical staff from the plans and local providers, and have identified issues on which to work collaboratively. For example, one result of these meetings is the recent agreement between Northeast Delta Human Services Authority and Richland Parish Hospital Service District (RPHSD) to collaboratively serve citizens through Richland Parish Hospital and RPHSD's Delhi Community Health Center. The MOAs provide coordinated care for people seeking behavioral health care and/or primary health care.

Behavioral Health Medical Director Role

Our Louisiana-based Behavioral Health Medical Director (BHMD) will serve as the LHCC senior executive responsible for the quality of the integration of medical and BH services and all LHCC BH activities. The BH Medical Director will be a physician with an unencumbered license through a State Board of Medical Examiners, and who is dedicated at least 10 hours weekly to this Agreement. Our BH Medical Director will be a board-certified psychiatrist licensed in the State of Louisiana, with at least five years of combined experience in mental health and substance abuse services.

Our BH Medical Director role will have four primary components with an overall goal of ensuring well-integrated care, and effective approaches and service delivery to maximize outcomes for members with BH conditions.

- ***Shape LHCC Policy and Programs.*** The BH Medical Director will be an integral member of our Medical Management team and participate in clinical and policy decision making to ensure an integrated focus. The BH Medical Director will also participate on the QAPI Committee and other Quality Committees to provide BH input into development and evaluation of quality strategies and performance improvement activities across our operations.
- ***Provide Clinical Direction to LHCC Activities Related to BH.*** The BH Medical Director will oversee behavioral health education and training for, and provide support and guidance to, clinical staff. This will include, but not be limited to case management consultations, participation in integrated case rounds, and assistance to Case Management Managers in monitoring and evaluating staff performance related to integrating medical and BH care. The BH Medical Director will oversee, monitor, and assist with the management of psychopharmacology pharmacy benefit manager (PBM) activities, including the establishment of prior authorization clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18.
- ***Provide Support to Network Providers.*** The BH Medical Director will develop a comprehensive care program for the management of youth and adult behavioral concerns typically treated by PCPs, such as ADHD and depression. The BH Medical Director will provide consultations and advice on BH care issues to PCPs treating behavior related concerns not requiring referral to a specialty BH provider, and assist in development of, and oversee provider training related to, early detection and evidence-based treatment of, and appropriate referrals and coordination for, BH conditions.
- ***Serve as Point of Accountability To, and Coordinate with, DHH and Key Stakeholders.*** The BH Medical Director will serve as the accountable liaison between LHCC and the SMO, to ensure smooth, effective collaboration on shared members. In addition, the BH Medical Director will be LHCC's representative to DHH for communication on BH issues, including, but not limited to participating in meetings, providing input on proposed policies, and raising identified issues to DHH staff and assisting in resolution.

J.2 Describe how you will coordinate with the Medicaid Dental Benefits Manager for the management of shared members, including processes for reciprocal referral for needed services.

Overview

LHCC coordinates with fee-for-service dental providers to ensure good oral health and integration of care for our members. We understand that untreated dental issues can have significant health consequences, particularly for those with chronic illness or who are pregnant. LHCC Case Management staff and MemberConnections™ Representatives (MCRs) assist members, including those with chronic and complex conditions, to identify and access carved out or non-Medicaid sources of dental care that may be available through state agencies and local social services organizations. Few resources exist for Medicaid-eligible adults to receive accessible preventive dental services, even though poor oral health affects overall health and may result in avoidable high-cost services such as ED visits for dental pain. To address this critical gap in coverage, LHCC will provide a Dental Value Added benefit for our adult members. This dental benefit will utilize our Federally Qualified Health Centers around the state who provide dental services, and will allow adults to access preventive services as well as basic dental treatments such as simple tooth extractions and fillings.

We also understand that certain medical conditions require more careful management of dental treatment, such as oral surgery for those with diabetes that is not well controlled; and that some medications for medical conditions may be contraindicated for use with local anesthesia used for dental procedures or post-procedure pain medication. Our Case Management staff handle needed coordination with dental providers, such as sharing information about the member's medical condition and needs to ensure safety and effectiveness of dental care. Additionally, Case Management staff will work with dental providers to obtain information gathered during dental evaluations that may indicate unaddressed medical needs or exacerbations of a chronic condition.

With the July 1, 2014 implementation of the Medicaid Dental Benefits Manager (DBM) Coordinated Dental Services contract, LHCC welcomes the opportunity to strengthen our coordination efforts for our members who need dental care. Our Vice President, Operations recently met with the DBM to discuss opportunities for coordination, and to develop a formal memorandum of understanding (MOU). A follow-up meeting is being scheduled to review formalized options and to discuss coordination of benefits. Our goal is to establish mutually agreed upon principles, and determine roles and responsibilities for coordinating and co-managing care. These principles and roles/responsibilities include, but are not limited to protocols for inter-plan communication, and reciprocal referral processes. We are also clarifying expectations for our respective network providers to collaborate with us in co-managing members, and we will collaborate on member education initiatives, such as health fairs and outreach to key populations, (e.g. pregnant women) for dental co-management.

LHCC understands and will comply with all DHH requirements relating to Coordinating with the Medicaid Dental Benefits Manager including, but not limited to Sections 6.5.2. Laboratory and Radiological Services; 6.8.1.7. Emergency Medical Services; 6.23.1. Medical Transportation Services; and 6.29. Care Coordination, Continuity of Care, and Care Transition.

Coordinated Outreach and Education to Increase Appropriate Dental Services Utilization

LHCC continually seeks to improve member access to primary and preventive care. We have discussed with the DBM the possibility of developing joint education and outreach initiatives, such as the following, to improve member and provider awareness of the importance of accessing dental care:

- Coordinated outreach and education for shared members emphasizing the connection between good oral health and general health
- Co-development of educational materials provided to pregnant mothers
- Co-branding or dual participation in local health fairs
- Collaborative development of a program like “Bright Beginnings,” which our Centene affiliate plan in Florida operates in conjunction with their DBM, which is the same as Louisiana’s current DBM vendor. This is a value added program that provides education to expectant mothers about the importance of healthy dental care.
- Joint outreach to PCPs and members, as well as individual outreach by both the MCO and DBM to their respective networks regarding the value of the dental benefit
- Outreach to pregnant members about good nutrition and its importance for oral health; and proper oral development in babies and children
- Joint education initiatives to members on tobacco cessation with emphasis on how tobacco use in any form increases the risks for gum disease and cancer
- Coordinated effort on a “Don’t Forget the Dental” campaign incorporated into in all EPSDT outreach to help ensure that all EPSDT required screening elements are completed
- Training for LHCC Customer Service and Case Management staff to include dental care reminders
- Coordinated Fax Reminders to PCPs twice a year to talk to members about the importance of following up with dental referrals as part of their screenings
- Joint protocols for LHCC’s Customer Service Department for warm transferring to the DBM call center for members who present with dental concerns.

Coordinating with the Medicaid DBM on Reciprocal Referral and Co-Management

LHCC Referral to DBM. LHCC will coordinate with the DBM to manage Bayou Health covered services with dental services. High priority members for referral to the DBM for co-management when dental services are needed will be those members eligible for the DBM dental benefit who:

- Are pregnant with periodontal disease
- Have a chronic or complex condition
- Require or are receiving transplant services
- Are co-managed by LHCC and the Statewide Management Organization (SMO)
- Are children with behavioral health (BH) and Intellectual and Developmental Disabilities (IDD) issues
- Are 18-21 years old with ED visits for dental pain (likely to present to ED for medication, not treatment)
- Have nutritional deficiencies due to poor dental health.

Identifying Members for Referral. We will identify members for referral to the DBM through Case and Utilization Management staff review or analysis of a variety of information/data sources, including:

Sources Used to Identify Members for Referral to DBM	
DHH claims provided at enrollment showing:	
•	EPSDT screenings for age eligible members with identified dental needs
•	Notice of Pregnancy (NOP) for age eligible members with identified dental needs

Sources Used to Identify Members for Referral to DBM
<ul style="list-style-type: none"> • Provider visits with claims related to dental needs • ED admissions data showing dental pain as a reason for the visit • Inpatient claims data showing aspiration or other dental-related needs for age eligible members
Our Health Risk Screening , conducted with all new Members within 30 days of enrollment, indicating a need for dental care
Provider referrals , including referrals related to dental needs identified during EPSDT screenings, and referrals from dental providers indicating medical needs
ED admissions data showing dental pain as a reason for the visit for age eligible members
Phone or in-person contact from members or family/caregivers requesting a referral for dental services
Vendor referrals related to dental needs and referrals from dental providers indicating medical needs

When we identify a member who may need referral to dental services, LHCC will use our holistic assessment process that features open-ended questions to foster an understanding of the full range of the member's needs. This includes, but is not limited to identifying needs for dental screenings, preventive dental care, periodontal care, and other dental services.

Reciprocal Referral Process. As part of our continuing discussions with the DBM vendor on development of an MOU, LHCC plans to suggest a reciprocal referral process. This process will incorporate a secure email address for each party to use for sending member referrals which contain protected health information (PHI). It also includes a form with critical elements to be provided by the referring party. These elements would include, but are not limited to, assessment results that indicate the need for the referred service(s), other health conditions, medications, treating provider information, and assigned Case Manager or other staff who serve as the point of contact for the member's case.

LHCC staff will document all referrals to and from the DBM in our TruCare health services management system to ensure and capture all the member's care. Case Management staff will also document follow-up contacts to ensure the member received the services for which we provided or received a referral.

Coordinating Care for Shared Members. As part of our MOU development discussions, LHCC will also work with the DBM to establish co-management protocols for shared members. For example, in addition to a reciprocal referral process that will supplement the activities LHCC will undertake to educate and refer members for needed dental services, we also will attempt to establish a process by which the DBM provides LHCC with a list of shared members they identify with gaps in dental care. This information will enable our Case Management staff, for example, to engage members in case management as part of the care planning process; and/or provide assistance, such as transportation, to obtain the dental services required.

In addition, Case Management staff, CSRs, NurseWise staff, and MCRs take the following actions to assist members in accessing dental services:

- Help the member identify available providers as well as obtain provider contact information
- Assist with appointment scheduling, as desired, by either establishing a three-way call with the member and selected provider to schedule an appointment; or by scheduling the appointment and communicating the information to the member by phone, secure messaging through our Member Portal, or by mail as preferred by the member
- Arrange transportation as needed; for members who need non-emergency transportation for a dentist appointment, LHCC helps the member schedule and arrange the needed transportation
- Schedule a reminder in TruCare for a staff member to remind the member in advance of the appointment.

When we identify members presenting at the emergency room, such as for dental pain, our Case Managers assist with referrals to the DBM, and provide transition plan information required for appropriate dental care follow up. Case Management staff assist the member, as needed, with scheduling and transportation, and follow up via phone to ensure the appointment was kept, and if not, work with the member to address barriers and reschedule.

Member Education and Assistance. LHCC educates all members about carved out Medicaid services, how to access them, and the assistance available through LHCC. Our Member Handbook, which is included in the New Member Welcome Packet mailed to all new members and available on our Member Portal, includes a list of carved out Medicaid services and information on accessing them, including dental services, and obtaining LHCC assistance. Our Customer Services Representatives (CSRs) and NurseWise (our 24/7 nurse advice line affiliate) staff educate members about dental services when they call our toll-free Member Call Center or NurseWise asking about the services. Our Case Managers educate members as part of the assessment and Care Plan development process. For example, pregnant members, who are at higher risk for periodontal disease, receive education and assistance with referrals for dental services from our Start Smart For Your Baby® Pregnancy Management Program Case Managers. In addition, our MCRs routinely provide information about accessing dental services at health fairs and other community events, and when meeting in person with members. Our addition of an adult dental value added service will expand our ability to connect our adult members to needed dental services.

Provider Education. We educate LHCC PCPs about the importance of referring members for dental services through initial provider orientation, in the Provider Manual, and on the Provider Portal. LHCC's Provider Relations staff also provide training to PCPs to complete dental screening during the member's well child visit and EPSDT screening for children aged 21 and younger.

Our Case Managers currently coordinate with waiver support coordinators, such as from the Community Choice Waiver and the NOW Waiver for members receiving those services.

J.3 Describe your approach for coordinating other carved out services including but not limited to Person Care Services, Targeted Case Management and other waiver specific services. Please include a description of how you will identify that your members may be in need of these services and any processes you will have in place for referral to and follow up with the member and provider or payer as appropriate.

Experience Coordinating Carved Out Services

Since our inception as a Bayou Health Plan, LHCC has coordinated with other carved out services (those in addition to dental and behavioral health services, described in our response to J.1 and J.2), including, but not limited to Personal Care Services (PCS), Targeted Case Management (TCM), and other waiver specific services. Our Case Management staff routinely coordinate non-covered services for all members, including, but not limited to our members on SSI receiving PCS and/or waiver services, and those with special health care needs receiving TCM. Staff integrate these carved out services with the preventive, primary, acute, and other services administered by LHCC. For example, our Case Management staff coordinate services for members with developmental disabilities with the Office for Citizens with Developmental Disabilities (OCDD). LHCC Case Managers also coordinate services and benefits with the DHH State Support Coordinator for members receiving TCM; Personal Care Attendant agencies for members who need PCS; and with Area Agencies on Aging for members receiving waiver services. Coordination includes securing physician orders when required and sharing information about the member's condition that may indicate the need for additional assistance with activities of daily living. We also require our Case Managers to complete online training to identify members who need to apply for

social security and other benefits of which they may not be aware, and refer them to the appropriate agency for assistance.

LHCC educates all members about PCS, TCM, and other waiver services. Our Member Handbook, which is included in the New Member Welcome Packet mailed to all new members and available on our Member Portal, includes a list of carved out Medicaid services, as well as information on accessing them and obtaining LHCC assistance. Our Customer Service Representatives (CSR) and NurseWise nurse advice line staff educate members about carved out services when they call our toll-free Member Call Center or nurse advice line to ask about the services. In addition, our Case Managers educate members as part of the assessment and care plan development process.

We educate providers to take a holistic approach to person-centered care that addresses member goals for their health, functioning, and quality of life. We educate LHCC PCPs about the importance of referring members for PCS, TCM, or waiver services through initial provider orientation in the Provider Manual and on the Provider Portal. We also promote coordination across the care continuum by supporting providers in achieving recognition as a Patient Centered Medical Home (PCMH), and offering financial incentives to provide PCMH services. The enhanced care coordination services offered by the PCMH improve the coordination of all services the member receives, including PCS, TCM, and other waiver services. We also support the development of medical neighborhoods that build from the PCMH out to other clinicians providing health care services to patients within it, and that include community and social service organizations and State and local public health agencies including, but not limited to, those that provide carved out and non-Medicaid services.

Under the new contract, LHCC will administer Personal Care Services (PCS) for members 0-21. This response addresses how we will coordinate PCS that will continue to be carved out for other members.

LHCC understands and will comply with all DHH requirements relating to coordinating with other carved out services, including, but not limited to Personal Care Services, Targeted Case Management, and other waiver specific services; RFP Sections 6.19.2 Medical Services for Special Populations; 6.23.1. Medical Transportation Services; 6.24. Excluded Services; 6.28.2.10 Referral System for Specialty Healthcare; 7.10.2. Patient Centered Medical Home; and all other relevant contractual and regulatory requirements.

Approach to Coordinating Carved Out Services, Including PCS, TCM, and Waiver Services

Our approach to coordinating any carved-out service is holistic, and recognizes that optimal health outcomes are only achieved when the full range of medical, behavioral, long-term, social, and other services are integrated and coordinated. Members with disabilities or chronic/complex conditions may require such services to support and maximize functioning and prevent, delay, or avoid exacerbations of their physical health condition that could result in hospital or nursing facility admission.

Our approach to coordinating covered Bayou Health services with PCS, TCM, and waiver services incorporates the following activities.

Coordination Activities
Identify members with special health care needs, including, but not limited to those receiving PCS, TCM, and waiver services
Complete comprehensive assessment for members with special needs to identify the full range of their medical, BH, long term, social, and other needs
Develop care plans that incorporate all needed services regardless of payer source
Coordinate and monitor care plans through sharing assessment, care plan, and monitoring information, with member consent and in accordance with all state and federal requirements, among the member's providers, regardless of network status

To ensure appropriate focus on members who need PCS, TCM, and/or waiver services, we have dedicated one of our Case Managers to managing and coordinating care for members who receive these services. In addition to managing cases, she serves as a Preceptor Trainer to share her expertise with these populations and services with our Case Management staff. She has more than ten years' experience working with TCM and waiver programs for the DHH Office of Aging and Adult Services and OCDD. In addition, she also is assisting with the development of Case Management training materials. Her significant experience with these services and programs will enhance our staff training and ability to coordinate effectively with PCS, TCM, and waiver services, and address the unique challenges and nuances of integrating these services with Bayou Health medical services. Understanding that behavioral health (BH) conditions are common in this subpopulation of members, we will assess these members for potential specialty BH needs, and coordinate, as applicable, with the Statewide Management Organization (SMO).

Identifying Members Who May Need Carved-Out Services

Case and Utilization Management staff identify members who may need carved-out services, including, but not limited to PCS, TCM, and waiver services, through assessments conducted when we identify a member with potential special health care needs. We also identify these members through initial and ongoing review of data sources, such as data that indicates new members who have existing PCS, TCM, or waiver services in place (e.g., existing care plans provided by DHH or another MCO and enrollment information indicating the member is a voluntary opt-in member). Additionally, we may identify members through referrals from sources such as LHCC providers, hospital staff, providers of non-covered services, state agency program staff, community and social service agencies (e.g., Area Agencies on Aging), members, caregivers/family, and LHCC staff (such as Customer Service Representatives or NurseWise staff receiving member calls, and Chronic Case Management Health Coaches who identify needs for non-covered services).

Staff identify the source through which a member is identified in TruCare, our integrated health services management system. Because we use multiple data and referral sources, we are able to quickly identify and assist members with non-covered service needs. Case Managers analyze summary results of the number of members referred by each source at least annually to assure we are actively monitoring a variety of sources to identify members.

Comprehensive Assessment

Case Management staff outreach to the member/family to schedule and complete a comprehensive, holistic assessment within 90 days of identifying members who may have special health care needs, such as needs for PCS, Targeted Case Management, or waiver services.. Our assessment process features open-ended questions to foster an understanding of the member's clinical co-morbidities, including special healthcare needs or disabilities, and catastrophic, high-cost, high-risk, co-morbid, or terminal conditions. Our approach is designed to not only identify needs related to core benefits and services, but the full range of member needs.

For new members with ongoing PCS, Long-Term Care, Adult Day Health Care, Community Choices Waiver, or any other Home and Community-Based Services (HCBS), our Case Managers coordinate the assessment with the member, family and/or caregiver, or Direct Service Workers (DS Worker). Case Managers contact Louisiana Options in Long Term Care to identify an appropriate point of coordination if the member is unsure who their DS Worker is, or if we are unable to reach or locate the DS Worker for those receiving PCS services. (We refer to coordination staff for these programs collectively as Support Coordinators throughout the remainder of this response.)

We gather information during the assessment such as member clinical history and status; functional status related to activities of daily living; mental health status, including psycho-social factors and cognitive function; caregiver resources, including family involvement and the family's participation in decision making; life planning activities, including wills, living wills, or advance directives; and cultural and linguistic needs and preferences.

Our assessment also gathers information about diagnoses and co-morbidity risks, comprehension of medication regime, hospital and ED use, activities of daily living, pain levels, confidence level in ability to manage primary condition, presence of BH conditions and disorders, psychosocial barriers to treatment compliance, and cultural and religious beliefs that affect health status. This assessment helps to further identify needs and clinical history that may not be available through claims data and predictive modeling.

These needs may include, but not be limited to:

- Special needs, such as developmental delay, severe orthopedic or persistent muscle tone abnormalities, seizure disorder, major chromosomal abnormalities
- Assistance needed with activities of daily living (e.g. bathing, toileting, dressing, ambulating) or instrumental activities of daily living (e.g. preparing meals, shopping, basic housekeeping, etc.), particularly when there is no support system
- Social or economic constraint such as lack of financial support; lack of social, family, or significant other support; illiteracy or significant communication barriers; access to care issues; transportation; or abuse or suspected abuse.

Care Planning, Referral, and Coordinating and Monitoring Services

In collaboration with the Member, family/caregiver, and network and out-of-network providers, and Support Coordinator, as applicable, the Case Manager develops a Care Plan within 30 days of completing the member's assessment. To facilitate development of the Care Plan, our Case Manager shares assessment and other information among all involved parties to ensure recommendations are informed by a holistic view of the member's needs and current services. The Care Plan is individualized and identifies the member's long and short term goals; desired service types, amounts and settings; member and caregiver/family participation, including the member's self-management responsibilities; plan for addressing barriers; and community linkages and support.

To ensure that all services are well coordinated, we incorporate all carved out services, as well as non-Medicaid services and those provided by community resources. Case

LHCC in Action...

We recently enrolled a seven-year old female member with a history of seizures, scoliosis, gastrostomy tube, encephalopathy, global delay, and mitochondrial metabolism disorder. Because her family had just moved to Louisiana, the mother, who speaks only Spanish, was unaware of available resources to meet her daughter's needs.

Our Case Manager helped the mother contact OCDD for information regarding waiver programs/state resources. Since OCDD does not have access to a translation line, the Case Manager connected the mother and OCDD with translation services using Voiance, LHCC's translator line, for the initial phone interview/intake process. The Case Manager and our translator also assisted OCDD with setting up an in-home assessment and interview with the mother/daughter. Our Case Manager and a Program Specialist are collaboratively managing the member's needs. The Program Specialist worked with the mother and the St. Mary School Board to get the member evaluated and approved for homebound services resulting in a weekly in-home visit with the member. The Program Specialist also coordinated with the Children's Choice Waiver Program to arrange a home assessment. The member was approved for the Program, and the Program Specialist will coordinate with the Support Coordinator to integrate the waiver services with Bayou Health services.

Management staff coordinate with external entities, including Support Coordinators and PCS, TCM, and waiver service providers, to ensure all needs are met and that treatment for one issue does not undermine or conflict with treatment by a different provider for another type of issue.

Processes for Referral. Case Management staff and MemberConnection™ Representatives (MCRs) assist members in accessing PCS, TCM, and other waiver services by:

- Helping the member identify available services through Area Agencies on Aging, Personal Care Attendant agency, and providers as well as contact information for referrals.
- Assisting with appointment scheduling, as desired, by either establishing a three-way call with the member and selected provider to schedule an appointment, or by scheduling the appointment and communicating the information to the member by phone, secure messaging through our Member Portal, or by mail, as preferred by the member.
- Arranging transportation as needed. LHCC provides non-emergency transportation for carved out services.
- Scheduling a reminder in TruCare for Case Management staff or the MCR to remind the member in advance of the appointment.

Coordinating Personal Care Services. PCS are critical for individuals who need assistance with activities of daily living. For all members currently receiving PCS at enrollment, or for whom DHH claims data indicates a history of receiving them, our Case Manager conducts a comprehensive assessment to determine the member's needs. If the member appears to need, but is not currently receiving PCS, the Case Manager refers the member to a Personal Care Attendant agency (PCS provider), assists as needed with making contact with the individual provider and/or the Louisiana Options in Long Term Care Hotline to obtain the member's provider contact information. Once obtained, the Case Manager collects all necessary assessment and other relevant information, with appropriate member consent, to assist the PCS provider in its own assessment and service plan development. The Case Manager documents contact information for the PCS provider in TruCare. Our Case Management staff coordinate any needed physician orders, obtain regular monitoring updates from the Support Coordinator, and share pertinent information about the member's covered services with the Support Coordinator.

Coordinating Targeted Case Management and Waiver Services. LHCC understands that DHH will continue to administer and pay for TCM services for infants and toddlers 0-36 months, EPSDT 3-20 with disabilities, HIV Disabled Individuals, and Nurse Family Partnership participants. We also are aware that LTSS consumers will continue to receive waiver services such as Community Choice and Adult Day Health Care through the Area Agencies on Aging; and members with developmental disabilities will continue to receive waiver services, such as EarlySteps and Individual Family Supports through OCDD.

When we identify a member receiving TCM and waiver services, a Case Manager contacts the member to conduct a comprehensive assessment, during which they obtain the name and contact information for the Support Coordinator. The Case Manager documents this information in TruCare and outreaches to the Support Coordinator to coordinate the LHCC Care Plan with TCM and waiver services. For example, when a member is hospitalized, the Case Manager or Transition of Care staff notifies the Support Coordinator and involves them in transition planning and follow up as applicable. In addition to ensuring an integrated approach to transition, this notification allows the staff to notify providers to discontinue services during the inpatient stay.

Case Managers also identify members who may be eligible for, but not receiving, TCM and/or waiver services, and provide referrals. They assist members in navigating the TCM eligibility process and waiver registry process, and in accessing the services. LHCC works with representatives of organizations that

serve members who are eligible for TCM and waiver services to identify additional mechanisms for coordinating these services with services covered by LHCC.

One issue that may arise in coordinating with TCM and waiver providers is member confidentiality. LHCC addresses this issue by working with the member, TCM and waiver provider, and, when necessary, the state Medicaid agency, to obtain and document member consent, and complete and maintain necessary information release agreements that comply with applicable State and federal privacy laws and regulations.

Follow-up with Member, Providers or Payer. Regardless of the payer, our Case Manager communicates assessment results, member goals and service preferences, and other information to the PCP and relevant treating providers (including PCS, TCM, and waiver providers) during the Care Plan development process. Once the Care Plan is complete, it is available via our Provider Portal after the Provider registers online to use the Portal. The Case Manager also shares information with the PCP and network/out-of-network treating providers, as well as the Support Coordinator, about ongoing communication with the member and results of monitoring service delivery and member condition and needs. The Case Manager coordinates among providers, as needed, to ensure each has all of the needed information about treatment and services being provided by others, as well as recommendations for covered and non-covered services.